HOUSE BILL No. 1696

DIGEST OF INTRODUCED BILL

Citations Affected: IC 12-7-2-131.8; IC 12-15-14.

Synopsis: Health facility reimbursement and bed licensing fee. Requires the office of Medicaid policy and planning (office): (1) to use additional federal funds for the state Medicaid program received through intergovernmental transfers and other methods involving health facilities to supplement Medicaid reimbursement for health facilities; (2) to modify Medicaid reimbursement for health facilities to remove expenses for property taxes from the capital rate component and calculate the expenses in a new rate component; (3) to calculate administrative and professional liability components of the case mix reimbursement as specified; (4) to recalculate, publish, and pay Medicaid reimbursements as specified; (5) to modify the Medicaid case mix reimbursement system for health facilities and reimburse health facilities as specified; (6) to reimburse health facilities that elect to increase wages or benefits, and pay bonuses to certain personnel as specified; and (7) to amend and adopt specified administrative rules. Establishes the eldercare trust fund consisting of funds to be collected from health facilities as a bed licensing fee of $6 for each patient day in the health facility. Requires the state's rate setting contractor to: (1) use the most recent completed year when calculating medians and provider rates; (2) calculate the median for each rate component each quarter using all cost reports received by the state within a specified timeframe; and (3) include in the calculation of the administrative medians and the health facility's reimbursement rates the initial amount of the licensing fee paid by the health facility. Prohibits the office from repealing or amending specified administrative rules. Voids LSA Document #02-13(F) concerning Medicaid reimbursement of health facilities.

Effective: Upon passage; March 31, 2003 (retroactive).

Crawford

January 21, 2003, read first time and referred to Committee on Ways and Means.

Introduced

First Regular Session 113th General Assembly (2003)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type.~~

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~*this style type*~~ reconciles conflicts between statutes enacted by the 2002 Regular or Special Session of the General Assembly.

HOUSE BILL No. 1696

A BILL FOR AN ACT to amend the Indiana Code concerning Medicaid and to make an appropriation.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. IC 12-7-2-131.8 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 131.8. "Most recent completed year", for purposes of IC 12-15-14, has the meaning set forth in IC 12-15-14-6(b).**

SECTION 2. IC 12-15-14-1, AS AMENDED BY P.L.160-2001, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 1. (a) Except as provided in subsection (b), payment of services for nursing facilities shall be determined under the same criteria and in a uniform manner for all facilities providing services.

(b) In addition to reimbursement under the uniform rates of payment developed for all nursing facilities under subsection (a):

(1) nursing facilities that are owned and operated by a governmental entity may receive any additional payments that are permitted under applicable federal statutes and regulations; and

(2) nursing facilities that are not owned and operated by a

governmental entity may receive any additional payments that are permitted under applicable federal statutes and regulations.

(c) Each governmental transfer or other payment mechanism that the office implements under this chapter must maximize the amount of federal financial participation that the state can obtain through the intergovernmental transfer or other payment mechanism.

(d) The office shall use any additional federal financial participation funds for the state Medicaid program that the state receives through an intergovernmental transfer or other payment mechanism involving health facilities to supplement Medicaid reimbursement for health facilities as required by sections 6 through 9 of this chapter. If any federal financial participation funds remain after funding sections 6 through 8 of this chapter, the remaining federal funds shall be used to supplement Medicaid reimbursement for health facilities under the same criteria and in a uniform manner for all health facilities.

SECTION 3. IC 12-15-14-6 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE MARCH 31, 2003 (RETROACTIVE)]: **Sec. 6. (a) Beginning April 1, 2003, the state's Medicaid rate setting contractor shall calculate medians and provider rates using the most recent completed year as defined in subsection (b).**

(b) "Most recent completed year", for purposes of this chapter and 405 IAC 1-14.6-7(a) and any successor rule, means the health facility's most recently completed fiscal year. The term does not mean the most recently completed cost reports on file.

SECTION 4. IC 12-15-14-7 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE MARCH 31, 2003 (RETROACTIVE)]: **Sec. 7. (a) Beginning April 1, 2003, the state's Medicaid rate setting contractor shall calculate the median for each rate component each quarter, using all cost reports received by the state or the state's rate setting contractor within one hundred fifty (150) days after each health facility's fiscal year end.**

(b) The state's Medicaid rate setting contractor shall request any additional information from a health facility not more than twenty-one (21) days after the cost report is received by the state's Medicaid rate setting contractor, and the state's Medicaid rate setting contractor shall include in the medians and the health facility's rate calculation all response received within one hundred ninety (190) days after the health facility's fiscal year end.

(c) If a draft audit report has been issued for a health facility

within one hundred fifty (150) days after the health facility's fiscal year end, the state's Medicaid rate setting contractor may request additional information relative to that draft audit report. If the draft audit report is issued more than one hundred fifty (150) days after the health facility's fiscal year end, the state's Medicaid rate setting contractor may not request additional information relative to that draft audit report for that rate review.

SECTION 5. IC 12-15-14-8 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE MARCH 31, 2003 (RETROACTIVE)]: **Sec. 8. Beginning April 1, 2003, the office shall modify the Medicaid reimbursement system for health facilities to remove expenses for property taxes from the capital component (as defined in 405 IAC 1-14.6-2 (g)) and calculate the expenses in a new rate component called property taxes. The office may not add a profit add-on payment (405 IAC 1-14.6-9(b)) to the calculation of the property taxes rate component. There is no limitation on the amount of the property taxes rate component in the rate calculation.**

SECTION 6. IC 12-15-14-9 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE MARCH 31, 2003 (RETROACTIVE)]: **Sec. 9. (a) The office shall calculate the administrative component (defined in 405 IAC 14.6-2(a)) and professional liability insurance component of the Medicaid case mix reimbursement system for health facilities as described in this section.**

(b) This subsection applies to a health facility that qualifies for participation in the patient compensation fund under IC 34-18 on April 1, 2003. The costs for professional liability insurance must be calculated as follows:

(1) The office shall remove the professional liability insurance expense from the administrative component of the case mix reimbursement system and calculate the expenses in a new rate component called professional liability insurance component.

(2) The office may not add a profit add-on payment (405 IAC 1-14.6-9(b)) to the calculation of the professional liability insurance rate component. There is no limitation on the amount of the professional liability insurance rate component in the rate calculation.

(3) If a health facility has less than one (1) complete year of patient compensation fund premium expense reported on the health facility's most recent submitted cost report, the office

shall allow the submission of the initial annual amount of professional liability insurance premiums for participation in the patient compensation fund for inclusion in the calculation of the professional liability insurance component.

(c) This subsection applies to a health facility that does not qualify for participation in the patient compensation fund under IC 34-18. The office shall include in the calculation of the administrative component the costs for professional liability insurance.

(d) This subsection applies to a health facility that does not qualify for participation in the patient compensation fund under IC 34-18 on April 1, 2003, but subsequently qualifies for the patient compensation fund.

(1) The office shall remove the professional liability insurance expense from the administrative component of the case mix reimbursement system and calculate the expenses in a new rate component called professional liability insurance component.

(2) The office shall add the initial annual amount of professional liability insurance premiums for participation in the patient compensation fund to the professional liability insurance expense removed from the administrative component. This calculation must be used until the facility has one (1) complete year of patient compensation fund premium expense included in the health facility's reported professional liability insurance expense. The office may not recognize a health facility's patient compensation fund premium expense more than one (1) time.

(3) The office may not add a profit add-on payment to the calculation of the professional liability insurance rate component. There is no limitation on the amount of professional liability insurance rate component in the rate calculation.

(4) The office shall adjust the health facility's rate on the first day of the month following the health facility's qualification for participation in the patient compensation fund. If this qualification occurs on the first day of the month, the health facility is eligible for a rate adjustment on the first day of that month.

(e) A health facility shall notify the office in writing that the health facility qualifies for participation in the patient compensation fund under IC 34-18.

SECTION 7. [EFFECTIVE UPON PASSAGE] **(a) The definitions in this SECTION apply throughout SECTIONS 8 through 20 of this act.**

(b) "Bed" refers to a comprehensive care bed.

(c) "Fund" refers to the eldercare trust fund established by this act.

(d) "Health facility" refers to a health facility licensed under IC 16-28 as a comprehensive care facility.

(e) "Office" refers to the office of Medicaid policy and planning established by IC 12-8-6-1.

(f) "Patient day" refers to a patient day as reported on:

(1) a health facility's Medicaid cost report if the health facility participates in the state Medicaid program; or

(2) the form developed by the office under SECTION 11 of this act if the facility does not participate in the state Medicaid program.

(g) This SECTION expires August 1, 2007.

SECTION 8. [EFFECTIVE UPON PASSAGE] **(a) The eldercare trust fund is established. The fund consists of the money deposited in the fund from the licensing fee collected under this act.**

(b) The expenses of administering the fund shall be paid from money in the fund.

(c) Interest that accrues from investing the money in the fund shall be deposited in the fund.

(d) The money in the eldercare trust fund is annually appropriated to the office and shall be used to pay the state's share of the costs for Medicaid services provided under Title XIX of the federal Social Security Act (42 U.S.C. 1396 et seq.) as follows:

(1) To reimburse health facilities for the allowable cost of the licensing fee imposed by this act as required by SECTION 9 of this act.

(2) To reimburse health facilities as required by IC 12-15-14-9, as added by this act.

(3) To reimburse health facilities as required by SECTION 16(a) of this act.

(4) To reimburse health facilities for the wage enhancements as required by SECTION 17 of this act.

(5) The remainder of the money as determined by the office.

(e) The money in the fund may not be used to reduce or replace the amount of state money that otherwise is being paid as of January 1, 2003, or that otherwise would be paid after January 1, 2003, if this act had not been enacted to reimburse health facilities

for Medicaid services provided under Title XIX of the federal Social Security Act (42 U.S.C. 1396 et seq.).

(f) Any federal financial participation funds that are obtained due to the expenditure required under subsection (d) must be expended for Medicaid services provided under Title XIX of the federal Social Security Act (42 U.S.C. 1396 et seq.) as described in subsection (d).

(g) If federal financial participation becomes unavailable to match money from the fund for the purpose of supplementing and enhancing reimbursement to health facilities for Medicaid services provided under Title XIX of the federal Social Security Act (42 U.S.C. 1396 et seq.), the office shall stop collection of the licensing fee under this act and refund any of the money remaining in the fund to the health facility that paid the licensing fee.

(h) This SECTION expires August 1, 2007. Money remaining in the fund on August 2, 2007, reverts to the state general fund.

SECTION 9. [EFFECTIVE UPON PASSAGE] **(a) Beginning August 1, 2003, the office shall collect a licensing fee from a health facility of six dollars ($6) for each patient day in the health facility. The office shall deposit the money collected in the eldercare trust fund established by SECTION 8 of this act.**

(b) This SECTION expires August 1, 2007.

SECTION 10. [EFFECTIVE UPON PASSAGE] **(a) This SECTION only applies to health facilities that participate in the state Medicaid program.**

(b) The office shall do the following:

(1) Determine the number of patient days for each health facility for the previous Medicaid cost reporting period.

(2) Determine the amount of the annual licensing fee for each health facility based upon the number of patient days. The licensing fee must be adjusted on an annual basis effective the first day of the second calendar quarter following the end of the health facility's Medicaid cost reporting year.

(3) Notify each health facility each year, not later than thirty (30) days after receipt of the health facility's cost report, of the amount of the annual licensing fee.

(4) Withhold one-twelfth (1/12) of each health facility's annual licensing fee each month through the Medicaid claims payment system. The annual licensing fee must be collected against the claims for service dates that coincide with the time period that the licensing fee is in effect.

(c) The licensing fee collected under this act is considered an

allowable cost for Medicaid reimbursement purposes in the administrative component (defined in 405 IAC 14.6-2(a)) of the Medicaid case mix reimbursement system.

(d) The office may not begin collection of the licensing fee under this act before the office calculates and begins paying new reimbursement rates for health facilities under this act.

(e) This SECTION expires August 1, 2007.

SECTION 11. [EFFECTIVE UPON PASSAGE] **(a) This SECTION only applies to health facilities that do not participate in the state Medicaid program.**

(b) The office shall develop and distribute to each health facility subject to this SECTION a form that will collect the following data:

(1) The total number of beds in the health facility.

(2) The number of patient days during the previous tax reporting period.

(c) Each health facility shall complete and submit the form described under subsection (b) to the office on an annual basis not later than ninety (90) days after the end of the health facility's tax reporting period. The time period for this report is equal to the health facility's tax reporting period.

(d) The office shall do the following:

(1) Determine the amount of the annual licensing fee for each health facility based upon the number of patient days during the previous tax reporting period. The licensing fee must be adjusted on an annual basis effective the first day of the second calendar quarter following the end of the health facility's tax reporting year.

(2) Notify each health facility each year, not later than thirty (30) days after receipt of the health facility's form, of the amount of the health facility's annual licensing fee.

(e) Beginning in August 2003 and ending in July 2007, each health facility shall pay one-twelfth (1/12) of the health facility's annual licensing fee to the office not later than the tenth day of each month.

(f) If a health facility pays the facility's annual licensing fee after the tenth day of the month or does not pay the annual licensing fee, the health facility shall pay interest on the fee at the rate of fifteen percent (15%) per day.

(g) This SECTION expires August 1, 2007.

SECTION 12. [EFFECTIVE UPON PASSAGE] **(a) This SECTION only applies to health facilities that participate in the**

state Medicaid program.

(b) Before June 15, 2003, the office shall do the following:

(1) Determine the number of patient days for each health facility for the previous Medicaid cost reporting period.

(2) Determine the amount of the annual licensing fee for each health facility based upon the number of patient days.

(3) Notify each health facility of the amount of the health facility's annual licensing fee.

(c) This SECTION expires July 1, 2003.

SECTION 13. [EFFECTIVE UPON PASSAGE] **(a) This SECTION only applies to health facilities that do not participate in the state Medicaid program.**

(b) Before June 15, 2003, the office shall develop and distribute to each health facility a form that will collect the following data:

(1) The total number of beds in the health facility.

(2) The number of patient days during the previous tax reporting period.

(c) Before July 1, 2003, each health facility shall complete and submit the form described in subsection (b). The time period for this report is equal to the health facility's tax reporting period.

(d) Before August 1, 2003, the office shall do the following:

(1) Determine the amount of the annual licensing fee for each health facility based upon the number of patient days during the previous tax reporting period.

(2) Notify each health facility of the amount of the annual licensing fee.

(e) This SECTION expires July 1, 2003.

SECTION 14. [EFFECTIVE UPON PASSAGE] **(a) The state's Medicaid rate setting contractor shall include in the calculation of:**

(1) the administrative medians for rate effective dates of July 1, 2003, through September 30, 2004; and

(2) each health facility's reimbursement rates with rate effective dates of July 1, 2003, through September 30, 2004;

the initial amount of the licensing fee that the health facility will pay under this act.

(b) This SECTION expires January 1, 2004.

SECTION 15. [EFFECTIVE UPON PASSAGE] **(a) Beginning August 1, 2003, the office shall recalculate, publish, and pay Medicaid reimbursement rates as modified by this act.**

(b) The state's Medicaid rate setting contractor shall calculate and notify health facilities of the health facility's rate under this act not later than September 1, 2003, using the most recent completed

cost reports on file as of May 31, 2003.

(c) This SECTION expires July 1, 2007.

SECTION 16. [EFFECTIVE UPON PASSAGE] **(a) The office shall modify the Medicaid case mix reimbursement system for health facilities to do the following:**

(1) Restore the profit add-on payment that existed before LSA Documents #00-277 and #02-13 took effect.

(2) Eliminate the sixty-five percent (65%) occupancy penalty on the direct care, indirect care, and administrative rate component of the case mix reimbursement system that were imposed by LSA Document #02-13.

(3) Restore the inflation adjustment that existed before LSA Document #00-277 and #02-13 took effect.

(b) This SECTION expires July 1, 2007.

SECTION 17. [EFFECTIVE UPON PASSAGE] **(a) The office shall reimburse each health facility that elects to:**

(1) increase the wages or benefits of; or

(2) pay bonuses;

in an amount not to exceed one dollar ($1) per hour for each registered nurse, licensed practical nurse, and certified nurse aide who is employed by the health facility. A health facility may only use the reimbursement for wage or benefit increases or for bonuses implemented after June 30, 2003. The total amount of wage, benefit, or bonus increases may not exceed one dollar ($1) per hour per individual during the effectiveness of this SECTION.

(b) A health facility may vary the amount of wages, benefits, or bonuses provided under this SECTION between individuals and between classes of employees eligible for the reimbursement. A health facility may not use the reimbursement provided under this SECTION to pay or increase wages or benefits for or to pay a bonus to an employee who works for the health facility under contract.

(c) The reimbursement provided under this SECTION is in addition to the reimbursement that a health facility would have received if this SECTION had not been enacted. However, the office may not consider the reimbursement provided under this SECTION in the calculation of the direct rate component or of the health facility's overall rate.

(d) To be eligible to receive the additional reimbursement, a health facility shall submit a plan for the additional reimbursement to the office at least thirty (30) days before the implementation date. The plan must describe the manner in which the health

facility will distribute the additional reimbursement to employees.

(e) For a health facility in which the employees are represented by an exclusive bargaining representative, an agreement negotiated and agreed to by the health facility and the exclusive bargaining representative constitutes the plan. A negotiated agreement may constitute the plan only if the agreement is finalized after the date of enactment of all increases for the health facility's rate year.

(f) The office shall review the plan to ensure that the bonus adjustment under this SECTION is effective on the first day of the month after the date that the health facility submits the plan to the office.

(g) A health facility that elects to receive additional reimbursement under this SECTION shall notify each employee eligible to receive a wage or benefit increase or bonus under the health facility's plan by giving the employee a copy of the plan or by posting the plan in an area of the health facility to which the employee has access.

(h) If:

(1) an eligible employee does not receive the wage or benefit adjustment or bonus described in the health facility's plan; and

(2) the eligible employee is unable to resolve the problem with the health facility's management or through an employee's union representative;

the employee may contact the office at an address or telephone number provided by the office and included in the health facility's plan.

(i) If the office determines that a health facility is not providing all or part of the wage or benefit increase or bonuses provided in the health facility's plan, the office may do the following:

(1) Terminate payment of the part of the additional reimbursement that is not being provided to employees as described in the health facility's plan and as required by this SECTION.

(2) Seek recoupment of any reimbursement that the office paid to the health facility but that was not paid to employees as described in the health facility's plan and as required by this SECTION.

(j) This SECTION expires June 30, 2007.

SECTION 18. [EFFECTIVE UPON PASSAGE] **(a) The office shall not do any of the following:**

(1) Repeal 405 IAC 1-14.6 without statutory authority enacted

after the effective date of this act.

(2) Amend 405 IAC 1-14.6 in any manner that reduces reimbursement for health facilities without statutory authority enacted after the effective date of this act.

(3) Adopt or amend any other rule under IC 4-22-2 or any other statute that reduces reimbursement for health facilities without statutory authority enacted after the effective date of this act.

(4) Repeal or amend a rule adopted under this act without statutory authority enacted after the effective date of this act.

(b) This SECTION expires July 1, 2007.

SECTION 19. [EFFECTIVE UPON PASSAGE] **LSA Document #02-13(F) is void.**

SECTION 20. [EFFECTIVE UPON PASSAGE] **(a) Not later than July 1, 2003, the office shall adopt emergency rules under IC 4-22-2-37.1 to amend 405 IAC 1-14.6 to implement:**

(1) IC 12-15-14-6;

(2) IC 12-15-14-7;

(3) IC 12-15-14-8; and

(4) IC 12-15-14-9;

all as added by this act, and to implement SECTION 16(a) of this act.

(b) Not later than January 1, 2004, the office shall adopt permanent rules under IC 4-22-2 to amend 405 IAC 1-14.6 to implement:

(1) IC 12-15-14-6;

(2) IC 12-15-14-7;

(3) IC 12-15-14-8; and

(4) IC 12-15-14-9;

all as added by this act, and to implement SECTION 16(a) of this act.

(c) This SECTION expires June 30, 2007.

SECTION 21. **An emergency is declared for this act.**